EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

MDL No. 2641
In Re Bard IVC Filter Products Liability Litigation

PLAINTIFF FACT SHEET

Each plaintiff who allegedly suffered injury as a result of a Bard Inferior Vena Cava Filter must complete the following Plaintiff Fact Sheet ("Plaintiff Fact Sheet"). In completing this Fact Sheet, you are **under oath and must answer every question.** You must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details as requested, please provide as much information as you can and then state that your answer is incomplete and explain why, as appropriate. If you select an "I Don't Know" answer, please state all that you do know about that subject. If any information you need to complete any part of the Fact Sheet is in the possession of your attorney, please consult with your attorney so that you can fully and accurately respond to the questions set out below. If you are completing the Fact Sheet for someone who cannot complete the Fact Sheet for himself/herself, please answer as completely as you can.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Fed. R. Civ. P. 33 and responses to requests for production pursuant to Fed. R. Civ. P. 34 and will be governed by the standards applicable to written discovery under Fed. R. Civ. P. 26 through 37. Therefore, you must supplement your responses if you learn that they are incomplete or incorrect in any material respect. The questions and requests for production of documents contained in this Fact Sheet are non-objectionable and shall be answered without objection. This Fact Sheet shall not preclude Bard Defendants from seeking additional documents and information on a reasonable, case-by-case basis, pursuant to the Federal Rules of Civil Procedure and as permitted by the applicable Case Management Order.

In filling out this form, "healthcare provider" shall mean any medical provider, doctor, physician, surgeon, pharmacist, hospital, clinic, medical center, physician's office, infirmary, medical/diagnostic laboratory, or any other facility that provides medical care or advice, along with any pharmacy, x-ray department, radiology department, laboratory, physical therapist/physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in your diagnosis, care and/or treatment.

In filling out this form, the terms "You" or "Your" refer to the person who received a Bard Inferior Vena Cava Filter manufactured and/or distributed by C. R. Bard, Inc. or Bard Peripheral Vascular, Inc. ("Bard Defendants") and who is identified in Question 1(a) below.

To the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary, Information provided by Plaintiff will only

be used for the purposes related to this litigation and may be disclosed only as permitted under the protective order in this litigation.

I. BACKGROUND INFORMATION

1. Please state:

   (a) Full name of the person who received the Bard inferior vena cava filter, including maiden name:_____

   (b) List all names by which you have ever been known, if different from that listed in 1(a):_____

   _____

   (c) Full name of the person completing this form, if different from the person listed in 1(a) above, and the relationship of the person completing this form to the person listed in 1(a) above: _____

   (d) The name and address of your primary attorney:

   _____

   _____

   _____

   _____

   (e) When did you first retain an attorney to represent you in your lawsuit against Bard? _____

2. Your Social Security Number: _____

3. Your Date of Birth: _____

4. Your current residential address:

   _____

   _____

   _____

   _____

5. If you have lived at this address for less than 10 years, provide each of your prior residential addresses from 2000 to the present:

Prior Residential Address	Dates You Lived At This Address

6. Have you ever been married? Yes_____ No_____

If yes, provide the names and addresses of each spouse and the inclusive dates of your marriage to each person:

_____

_____

_____

7. Do you have children? Yes_____ No_____

If Yes, please provide the following information with respect to each child:

Full Name of Child	Date of Birth	Home Address	Whether Biological/Adopted

8. Identify the name and age of any person who currently resides with you and their relationship to you:

_____

_____

_____

9. Identify the name and age of any person who has resided with you at any point over the past ten (10) years:

_____

_____

_____

10. Identify all secondary and post-secondary schools you attended, starting with high school, and please provide the following information with respect to each:

Name of School	Address	Dates of Attendance	Degree Awarded	Major or Primary Field of Study

11. Please provide the following information for your employment history over the past 10 years up until the present:

Employer Name	Address	Job Title/Description of Duties	Dates of Employment	Salary/Rate of Pay

12. Have you ever served in any branch of the military? Yes_____ No_____

If Yes, please provide the following information:

(a) Branch and dates of service, rank upon discharge, and type of discharge received:

_____

(b) Were you discharged from the military at any time for any reason relating to your medical, physical, or psychiatric condition? Yes_____ No_____

If Yes, state what that condition was:_____

_____

13. Within the last ten years, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty? Yes_____ No_____

If Yes, please set forth where and when and identify the felony and/or crime:

_____

_____

_____

14. Before contacting any attorney regarding this lawsuit or claim, had you ever seen any television or print advertisements regarding possible claims against inferior Vena Cava Filter manufacturers?

Yes_____ No_____

If Yes, set forth the approximate date and nature of any such advertisement, whether the advertisement included the name of a law firm, whether the advertisement specifically mentioned C. R. Bard, Inc., Bard Peripheral Vascular, Inc., or "Bard", and other details that you recall. _____

_____

_____

_____

II. CLAIM INFORMATION

1. Have you ever received a Bard Inferior Vena Cava Filter? Yes_____ No_____

If Yes, please check the box(es) for each type of Bard Inferior Vena Cava Filter you have received:

☐ Recovery®

☐ G2®

☐ G2®X

☐ G2®Express

☐ Eclipse®

☐ Meridian®

☐ Denali®

☐ Other (please identify):_____

2. For each Bard Inferior Vena Cava Filter identified above, please provide the following information:

(a) The date each Bard Inferior Vena Cava Filter was implanted in you:

_____

(b) The product code and lot number of each Bard Inferior Vena Cava Filter implanted in you:

_____

(c) Current location of the Bard Inferior Vena Cava Filter, including any portion thereof, if known:

_____

_____

_____

3. Describe your understanding of the medical condition for which you received the Bard Inferior Vena Cava Filter(s):

_____

_____

4. Give the name and address of the doctor who implanted the Bard Inferior Vena Cava Filter(s):_____

_____

5. Give the name and address of the hospital or other healthcare facility where the Bard Inferior Vena Cava Filter was implanted:_____

_____

6. Have you ever been implanted with any other vena cava filters or related product(s) besides the Bard Inferior Vena Cava Filter(s) for the treatment of the same or similar condition(s) identified in your response to question 3 above? Yes_____ No_____

If Yes:

(a) Please identify any such device(s) or product(s)._____

_____

(b) When was this device or product implanted in you?_____

_____

(c) Did the implantation take place before, at the same time, or after the procedure during which you were implanted with a Bard Inferior Vena Cava Filter?

_____

_____

(d) Who was the physician who implanted this other device or product?

_____

_____

(e) At what hospital or facility was this other device or product implanted in you?

_____

_____

(f) Why was this other device or product implanted in you?

_____

_____

7. Prior to implantation with a Bard Inferior Vena Cava Filter, did you receive any written and/or verbal information or instructions regarding the Bard Inferior Vena Cava Filter, including any risks or complications that might be associated with the use of the same?

Yes_____ No_____ Don't Know_____

If Yes:

(a) Provide the date you received the written and/or verbal information or instructions:

_____

_____

(b) Identify by name and address the person(s) who provided the information and instructions:

_____

_____

(c) What information or instructions did you receive?

_____

_____

(d) If you have copies of the written information or instructions you received, please attach copies to your response.

_____

_____

(e) Were you told of any potential complications from the implantation of the Bard Inferior Vena Cava Filter(s)? Yes _____ No _____ Don't Know _____

(f) If yes to (e), by whom?

_____

_____

(g) If yes to (e), what potential complications were described to you?

_____

_____

8. Do you believe that the Bard Inferior Vena Cava Filter(s) remains implanted in you?

Yes _____ No _____ Don't Know _____

If Yes:

(a) Has any doctor recommended removal of the Bard Inferior Vena Cava Filter(s)?

Yes _____ No _____

If Yes:

(i) Identify by name and address every doctor who recommended removal of the Bard Inferior Vena Cava Filter(s):_____

_____

_____

(ii) For each doctor identified in response to question 8(a)(i) above, state your understanding of why the doctor recommended removal._____

_____

_____

(iii) For each doctor identified in response to question 8(a)(i) above, state when the doctor recommended removal._____

_____

_____

9. Has the Bard Inferior Vena Cava Filter(s) implanted in you been removed, in whole or in part?

Yes_____ No_____ Don't Know_____

If Yes:

(a) Where, when, and by whom was the Bard Inferior Vena Cava Filter(s), or any portion of it, removed?_____

_____

_____

(b) What portion of the Bard Inferior Vena Cava Filter(s) was removed on the date indicated in response to question 9(a) above?_____

_____

_____

(c) Please check all that apply regarding the removal procedure(s):

☐ Removed percutaneously

☐ Removed via an open abdominal procedure

☐ Removed via an open chest procedure

☐ Other, Describe: _____

☐ Unknown

(d) Does any portion of the Bard Inferior Vena Cava Filter(s) remain implanted in you? Yes _____ No _____ Don't Know _____

If Yes, explain what portion of the Bard Inferior Vena Cava Filter(s) you believe is still implanted in you:_____

_____

_____

(e) Explain why you consented to have the Bard Inferior Vena Cava Filter(s), or any portion thereof, removed?

_____

_____

_____

(f) Does any medical provider, physician, entity, or anyone else acting on your behalf have possession of any portion of the Bard Inferior Vena Cava Filter that was previously implanted in you and subsequently removed?

Yes_____ No_____ Don't Know_____

If Yes, please state the name and address of the person or entity having possession of same._____

_____

10. Has any doctor or healthcare provider unsuccessfully attempted to remove the Bard Inferior Vena Cava Filter(s) implanted in you?

Yes_____ No_____ Don't Know_____

If Yes:

(a) How many attempts have been made to remove the Bard Inferior Vena Cava Filter(s) implanted in you?_____

(b) Provide the name and address of the doctor who removed (or attempted to remove) the filter strut(s) and the hospital or medical facility at which it was removed (or attempted to be removed).

Filter Removal/Attempted Removal #1

Doctor:_____

Hospital/Medical Facility:_____

Date:_____

Filter Removal/Attempted Removal #2

Doctor:_____

Hospital/Medical Facility:_____

Date:_____

Filter Removal/Attempted Removal #3

Doctor:_____

Hospital/Medical Facility:_____

Date:_____

(c) Please check all that apply regarding attempted removal procedure #1:

☐ Attempted but unsuccessful percutaneous removal procedure

☐ Attempted but unsuccessful open abdominal procedure

☐ Attempted but unsuccessful open chest procedure

☐ Other, Describe: _____

_____

☐ Unknown

(d) Please check all that apply regarding attempted removal procedure #2:

☐ Attempted but unsuccessful percutaneous removal procedure

☐ Attempted but unsuccessful open abdominal procedure

☐ Attempted but unsuccessful open chest procedure

☐ Other, Describe: _____

_____

☐ Unknown

(e) Please check all that apply regarding attempted removal procedure #3:

☐ Attempted but unsuccessful percutaneous removal procedure

☐ Attempted but unsuccessful open abdominal procedure

☐ Attempted but unsuccessful open chest procedure

☐ Other, Describe: _____

_____

☐ Unknown

11. Do you claim that your Bard Inferior Vena Cava Filter(s) fractured?

Yes_____ No_____

If Yes:

(i) Please state the number of fractured struts retained in your body?

_____

(ii) Please identify the location(s) within your body of each retained filter strut.

_____

_____

(iii) Please provide the date or approximate date when you were first informed of each fractured strut.

_____

_____

(iv) Has any health care provider recommended to you that a retained filter strut(s) should be removed?

Yes _____ No_____

If Yes, provide the name and address of any such healthcare provider, as well as the approximate date on which the communication occurred.

_____

_____

_____

(v) Has any health care provider recommended to you that a retained filter strut should not be removed?

Yes_____ No_____

If Yes, provide the name and address of any such healthcare provider, as well as the approximate date on which the communication occurred.

_____

_____

_____

(vi) Have any fractured struts been removed, or attempted to have been removed, from your body?

Yes _____ No_____

If Yes:

(1) If any fractured filter strut has been removed (or a doctor has attempted to remove any strut), please check all that apply regarding the removal/attempted removal procedure(s):

☐ Removed percutaneously

☐ Removed via an open abdominal procedure

☐ Removed via an open chest procedure

☐ Attempted but unsuccessful percutaneous removal procedure

☐ Attempted but unsuccessful open abdominal procedure

☐ Attempted but unsuccessful open chest procedure

☐ Other, Describe: _____

☐ Unknown

(2) Provide the name and address of the doctor who removed (or attempted to remove) the filter strut(s) and the hospital or medical facility at which it was removed (or attempted to be removed).

Filter *Strut* Removal/Attempted Removal #1

Doctor:_____

Hospital/Medical Facility:_____

Date:_____

Filter *Strut* Removal/Attempted Removal #2

Doctor:_____

Hospital/Medical Facility:_____

Date:_____

12. Do you claim that you suffered bodily injuries as a result of the implantation of the Bard Inferior Vena Cava Filter(s)? Yes_____ No_____

If Yes:

(a) Describe the bodily injuries, including any emotional or psychological injuries that you claim resulted from the implantation, attempted removal and/or removal of the Bard Inferior Vena Cava Filter(s)?_____

_____

_____

(b) When was the first time you experienced symptoms of any of the bodily injuries you claim in your lawsuit to have resulted from the Bard Inferior Vena Cava Filter(s)?

_____

_____

(c) When did you first attribute these bodily injuries to the Bard Inferior Vena Cava Filter(s)?_____

_____

(d) To the best of your knowledge and recollection, please state the approximate date when you first saw a health care provider for any of the bodily injuries, or symptoms related thereto, you claim to have experienced related to the Bard Inferior Vena Cava Filter(s)?

_____

_____

_____

(e) To the best of your knowledge and recollection, has any health care provider ever told you orally or in writing that any symptoms related to bodily injury are related to the Bard Inferior Vena Cava Filter(s)?

Yes_____ No_____

If Yes, please state the name and address of any such health care provider, as well as providing the approximate date the statement was made, and provide the details of the communication:_____

_____

_____

_____

_____

(f) Are you currently experiencing symptoms related to your claimed bodily injuries?

Yes_____ No_____

If Yes, please describe your symptoms in detail:

_____

_____

(g) Are you currently seeing, or have you ever seen, a doctor or healthcare provider for any of the bodily injuries or symptoms listed above?

Yes_____ No _____

If Yes, please list all doctors you have seen for treatment of any of the bodily injuries you have listed above.

Provider Name and Address	Condition Treated	Approximate Dates of Treatment

h) Were you hospitalized at any time for the bodily injuries you listed above?

Yes _____ No_____

If Yes, please provide the following:

Hospital Name and Address	Condition Treated	Approximate Dates of Treatment

13. Are you making a claim for lost wages or lost earning capacity?

Yes_____ No_____

(a) If yes, state the annual gross income derived from your employment for each year, beginning five (5) years prior to the implantation of the Bard Inferior Vena Cava Filter(s) until the present: _____

_____

_____

(b) If yes, for what period of time are you claiming lost wages?_____

_____

_____

(c) If you are claiming lost earning capacity, do you claim that you have a claim for future lost wages?

Yes_____ No_____

If yes, for what period of time do you claim you have lost future wages?

_____

_____

_____

14. Are you making a claim for lost out-of-pocket expenses? Yes_____ No_____

If yes, please identify and itemize all out-of-pocket expenses you have incurred.

_____

_____

_____

15. Has anyone filed a loss of consortium claim in connection with your lawsuit regarding the Bard Inferior Vena Cava Filter(s)?

Yes_____ No_____

If yes, identify by name and address the person who filed the loss of consortium claim ("Consortium Plaintiff") and state the relationship of that person to you and state the specific nature of the Consortium Plaintiff's claim._____

_____

_____

_____

16. Please indicate whether the Consortium Plaintiff alleges any of the damages set forth below:

Claims	Yes/No
Loss of services of spouse	
Impaired sexual relations	
Lost wages/lost earning capacity	
Lost out-of-pocket expenses	
Physical injuries	
Psychological injuries/emotional injuries	
Other	

17. Please list the name and address of any healthcare providers the Consortium Plaintiff has sought treatment for any physical, emotional, or psychological injuries or symptoms alleged to be related to his/her claim._____

_____

_____

_____

18. Have you or anyone acting on your behalf had any communication, oral or written, with any of the Bard Defendants and/or their representatives?

Yes _____ No_____ Don't Know _____

If yes, set forth: (a) the date of any communication, (b) the method of communication, (c) the name of the person with whom you communicated, and (d) the substance of the communications._____

_____

_____

III. MEDICAL BACKGROUND

1. Provide your current: Age_____ Height_____ Weight_____
2. Provide your: Age_____ Weight_____ (approximate, if unknown) at the time the Bard Inferior Vena Cava Filter was implanted in you.
3. In chronological order, list any and all surgeries, procedures and/or hospitalizations you had in the ten (10) year period BEFORE implantation of the Bard Inferior Vena Cava Filter(s). Identify by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

Approximate Date	Description of Surgery or Hospitalization	Doctor or Healthcare Provider Involved (including address)

[Attach additional sheets as necessary to provide the same information for any and all surgeries and hospitalizations leading up to the implantation of the Bard Inferior Vena Cava Filter.]

4. In chronological order, list any and all surgeries, procedures and/or hospitalizations you had AFTER implantation of the Bard Inferior Vena Cava Filter(s). Identify by name and address the doctor(s), hospital(s) or other healthcare provider(s) involved with each surgery or procedure; and provide the approximate date(s) for each:

Approximate Date	Description of Surgery or Hospitalization	Doctor or Healthcare Provider Involved (including address)

[Attach additional sheets as necessary to provide the same information for any and all surgeries and hospitalizations after the implantation of the Bard Inferior Vena Cava Filter.]

5. To the extent not already provided in the charts above, provide the name, address, and telephone number of every doctor, hospital or other health care provider from which you have received medical advice and/or treatment from ten (10) years before the date the filter was implanted to the present:

Name and Specialty	Address	Approximate Date/Years of Visits

6. *Before the implantation* of the Bard Inferior Vena Cava Filter(s), did you regularly exercise or participate in activities that required lifting or strenuous physical activity? (Please include all physical activities associated with daily living, physical fitness, household tasks, and employment-related activities.)

Yes _____ No _____

If yes, please describe each activity in detail. _____

_____

_____

_____

7. *Since the implantation* of the Bard Inferior Vena Cava Filter(s), have you regularly exercised or participated in activities that required lifting or strenuous physical activity? (Please describe all range of physical activities associated with daily living, physical fitness, household tasks, and employment-related activities.)

Yes _____ No _____

If yes, please describe each activity in detail. _____

_____

_____

_____

8. During the past ten (10) years, what have been your primary hobbies or recreational activities? _____

_____

_____

_____

(a) Do you claim that you are unable to participate in any of the hobbies or recreational activities listed in response to question 8 above as a result of you having been implanted with a Bard Inferior Vena Cava Filter(s)?

Yes_____ No_____

(b) If yes, what hobbies or recreational activities do you claim that you are unable to participate in as a result of having been implanted with a Bard Inferior Vena Cava Filter(s)?_____

_____

_____

(c) For what period of time do you claim that you were or have been unable to participate in any hobbies or recreational activities as a result of having been implanted with a Bard Inferior Vena Cava Filter(s)?

_____

_____

_____

9. To the best of your knowledge, have you ever been told by a doctor or another health care provider that you have suffered, may have suffered, or presently do suffer from any of the following:

_____ Lupus

_____ Crohn's Disease

_____ Factor V Leiden

_____ Protein Deficiency

_____ Spinal Fusion or Other Back Procedures

_____ Anti-thrombin Deficiency

_____ Prothrombin Mutation

_____ Deep Vein Thrombosis

_____ Pulmonary Embolism

_____ Auto Immune Disorder

_____ Varicose Veins

_____ Heart Procedures

_____ Blood Disorder

Please Describe:_____

_____ Bariatric Surgery

_____ Anticoagulation Medication (e.g., Coumadin, Warfarin, etc.)

_____ Ulcerative Colitis/Inflammatory Bowel Disease (IBD)

_____ Cancer

Please Describe:_____

* * * * * * * * * *

THE FOLLOWING QUESTIONS ARE CONFIDENTIAL AND SUBJECT TO THE PROTECTIVE ORDER APPLICABLE TO THIS CASE.

(A) Have you been diagnosed with and/or treated for any drug, alcohol, chemical and/or other addiction or dependency during the five (5) years prior to the filing of this lawsuit through the present? Yes_____ No_____

If yes, specify type and time period of dependency, type of treatment received, name of treatment provider, and current status of condition:

_____

_____

_____

_____

(B) Have you experienced, been diagnosed with or received psychiatric or psychological treatment of any type, including therapy, for any mental health conditions including depression, anxiety, or other emotional or psychiatric disorders during the five (5) years prior to the filing of this lawsuit through the present? Yes_____ No_____

If yes, specify condition, date of onset, medication/treatment, treating physician and current status of condition:

_____

_____

_____

_____

* * * * * * * * * *

10. Do you now or have you ever smoked tobacco products? Yes_____ No_____

If yes:

How long have/did you smoke?_____

11. Other than the implantation of the Bard Inferior Vena Cava Filter device that is the subject of your lawsuit, are you aware of any other Vena Cava Filter(s) implanted inside your body at any time? Yes_____ No_____

If yes, please provide the following information:

(a) Product name:_____

(b) Date of procedure placing it and name and address of doctor who placed it:

_____

(c) Condition sought to be treated through placement of the device:

_____

(d) Any complications you encountered with the medical product or procedure:

_____

(e) Does that product remain implanted inside of you today? Yes_____ No_____

12. List each prescription medication you have taken for more than three (3) months at a time during the timeframe beginning five (5) years prior to implantation of the Bard Inferior Vena Cava Filter and continuing to the present, giving the name and address of the pharmacy where you received/filled the medication, the reason you took the medication, and the approximate dates of use.

Medication and Dosage	Prescribing Physician	Pharmacy Name and Address	Reason for Taking Medication	Approximate Date(s) of Use

IV. INSURANCE INFORMATION

1. Provide the following information for any past or present medical insurance coverage from the timeframe beginning five (5) years prior to implantation of the Bard Inferior Vena Cava Filter and continuing to the present:

Insurance Company Name and Address	Policy Number	Name of Policy Holder/Insured (if different than yourself)	Approximate Dates of Coverage

2. To the best of your knowledge, have you ever been approved to receive or are you currently receiving Medicare/Medicaid benefits due to age, disability, condition, or any other reason or basis?

Yes_____ No_____

If yes, please specify the date on which you first became eligible:_____

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

V. PRIOR CLAIM INFORMATION

1. Have you filed a lawsuit or made a claim in the last ten (10) years, other than in the present suit relating to any bodily injury?

Yes_____ No_____

If yes, please specify the following:

(a) Court in which the lawsuit/claim was filed or initiated:_____

_____

(b) Case/Claim Number:_____

(c) Nature of Claim/Injury:_____

_____

2. Have you ever applied for Workers' Compensation (WC), Social Security disability (SSI or SSD) benefits, or other State or Federal disability benefits?

Yes_____ No_____

If yes, please specify the following:

(a) Date (or year) of application:_____

(b) Type of benefits sought:_____

(c) Agency/Insurer from which you sought the benefits:_____

_____

(d) Nature of the claimed injury/disability:_____

_____

(e) Whether the claim was accepted or denied:_____

VI. FACT WITNESSES

1. Identify by name, address, and relationship to you, all persons (other than your healthcare providers) who possess information concerning your injuries and/or current medical condition:

Name	Address	Relationship to You	Information You Believe Person Possesses

VII. IDENTIFICATION OF DOCUMENTS AND OTHER ELECTRONICALLY STORED INFORMATION

For the period beginning three (3) years prior to the implantation of the Bard Inferior Vena Cava Filter until the present, please identify all research, including on-line research, that you conducted regarding the medical complaints or condition for which you received the Bard Inferior Vena Cava Filter (pulmonary thromboembolism, anticoagulant therapy, etc.) Identify the date, time, and source, including any websites visited. (Research conducted subsequent to and for the purpose of understanding the legal and strategic advice of your counsel is not considered responsive to this request.)

_____

_____

_____

_____
_____
_____
_____

VIII. DOCUMENT REQUESTS

1. RELEASES.

NOTE: Please sign and attach to this Fact Sheet the authorizations for the release of records appended hereto.

2. DOCUMENTS. State whether you have any of the following documents in your possession, custody, and/or control. If you do, please provide a true and correct copy of any such documents with this completed Fact Sheet.

(a) If you were appointed by a Court to represent the plaintiff in this lawsuit, produce any documents demonstrating such appointment.

(i) Not applicable _____

(ii) The documents are attached_____ [OR] I have no documents_____

(b) If you represent the Estate of a deceased person in this lawsuit, produce a copy of the decedent's death certificate and autopsy report (if applicable).

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(c) Produce each and every medical record of each and every medical facility, pharmacy, or practitioner of the healing arts identified by you in response to the questions in Sections II and III above regarding your medical care and history for the time period beginning ten (10) years prior to the implantation of the Bard Inferior Vena Cava Filter and continuing to the present.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(d) Produce any communication (sent or received) in your possession, which shall include materials accessible to you from any computer on which you have sent or received such communications, concerning the Bard Inferior Vena Cava Filter(s) or subject of this litigation, including, but not limited to all letters, emails, blogs, Facebook posts, Tweets, newsletters, etc. sent or received by you. (Research

conducted subsequent to and to understand the legal and strategic advice of your counsel is not considered responsive to this request.)

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(e) Produce all documents, including journal entries, lists, memoranda, notes, diaries, photographs, video, DVDs or other media, discussing or referencing the Bard Inferior Vena Cava Filter(s), the injuries and/or damages you claim resulted from the Bard Inferior Vena Cava Filter(s), and/or evidencing your physical condition from three (3) years prior to the implantation of the Bard Inferior Vena Cava Filter(s) to present. (Research conducted subsequent to and to understand the legal and strategic advice of your counsel is not considered responsive to this request.)

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(f) Produce any Bard Inferior Vena Cava Filer product packaging, labeling, advertising, or any other product-related items in your possession, custody or control.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(g) Produce all documents concerning any communication between you, your attorney(s), your agent(s), your expert(s), or your representative(s) and the Food and Drug Administration (FDA), or between you and any employee or agent of the Bard Defendants, regarding Bard Inferior Vena Cava Filters.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(h) Produce all documents that you, your attorney(s), your agent(s), your expert(s), or your representative(s) provided to the Food and Drug Administration (FDA) and/or the Department of Health and Human Services regarding Bard Inferior Vena Cava Filters.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(i) Produce all documents concerning any communication between you, your attorney(s), your agent(s), your expert(s), or your representative(s) with anyone at any television station, radio station, newspaper, periodical, magazine, weblog, internet website, or any other media outlet regarding Bard Inferior Vena Cava Filters.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(j) Produce all documents that you, your attorney(s), your agent(s), your expert(s), or your representative(s) provided to anyone at any television station, radio station, newspaper, periodical, magazine, weblog, internet website, or any other media outlet regarding Bard Inferior Vena Cava Filters.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(k) Produce all documents in your possession, custody, or control evidencing or relating to any correspondence or communication between C. R. Bard, Inc. or Bard Peripheral Vascular, Inc. (or any related companies or divisions) and any of your doctors, healthcare providers, and/or you relating to Bard Inferior Vena Cava Filters, except as to those communications which are protected by the attorney-client privilege or attorney work product doctrine.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(l) Produce all documents in your possession, custody, or control reflecting, describing, or in any way relating to any instructions or warnings you received prior to implantation of any Inferior Vena Cava Filter(s) concerning the risks and/or benefits associated with Inferior Vena Cava Filter(s), including but not limited to the Bard Inferior Vena Cava Filter implanted in you.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(m) Produce any and all documents reflecting the model number and lot number of the Bard Inferior Vena Cava Filter(s) you received.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(n) If you underwent surgery or any other procedure to remove, in whole or in part, the Bard Inferior Vena Cava Filter(s), produce any and all documents, other than documents that may have been generated by expert witnesses retained by your counsel for litigation purposes, that relate to any evaluation of the Bard Inferior Vena Cava Filter(s) removed from you.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(o) Produce all documents in your possession, custody, or control concerning payment by Medicare on behalf of the injured party and relating to the injuries claimed in this lawsuit. This includes, but is not limited to Interim Conditional Payment summaries and/or estimates prepared by Medicare or its representatives regarding payments made on your behalf for medical expenses relating to the subject of this litigation.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

[Please note: if you are not currently a Medicare-eligible beneficiary, but become eligible for Medicare during the pendency of this lawsuit, you must supplement your response at that time. This information is necessary for all parties to comply with Medicare regulations. See 42 U.S.C. 1395y(b)(8), also known as Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 and 42 U.S.C. 1395y(b)(2) also known as the Medicare Secondary Payer Act.]

(q) Produce all screenshots of all webpages of each type of social media used by you (including, but not limited to, Facebook, Twitter, Instagram, Vine, Snapchat, YouTube, LinkedIn) showing any and all "posts" and/or "messages" from the date of implantation to the present.

(i) Not applicable_____

(ii) The documents are attached_____ [OR] I have no documents_____

(r) Produce the Bard Inferior Vena Cava Filter(s) or any and all components thereof previously implanted in you.

VERIFICATION

I, _____, declare under penalty of perjury, subject to all applicable laws and in the presence of the below named witness, that I have carefully reviewed the final copy of this Plaintiff Fact Sheet dated _____ and verified that all of the information provided is true and correct to the best of my knowledge, information and belief.

_____ _____

Signature of Witness Signature of Plaintiff

_____

Name of Witness

_____

Address of Witness